



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

GLENN J BRICKEN & ASSOC

MFDR Tracking Number

M4-15-3357-01

MFDR Date Received

June 10, 2015

Respondent Name

UNIVERSITY OF TEXAS SYSTEM

Carrier's Austin Representative

Box Number 46

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Carrier accepted the compensable injury caused by a motor vehicle on [date of injury]. Services were preauthorized, provided and paid accordingly. The Carrier then requested a refund indicating the claims were paid in error. Corrective claims have been submitted to the carrier correcting the diagnosis [diagnosis code] to [diagnosis code] due to a data entry error. The medical documentation clearly shows treatment for a [injury]. We believe reimbursement of these claims was appropriate and as such are disputing the request for a refund according to 133.305(4)(c) [sic]."

Amount in Dispute: \$411.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In this case, Dr. Bricken has not refunded the amount that UT System paid to him despite UT System's timely demand for a refund. Until he does, he is not entitled to dispute resolution. Therefore, the Division should dismiss his request."

Response Submitted by: Stone Loughlin & Swanson, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 28, 2014 and August 14, 2014	90837 x 2	\$411.24	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.260 sets out the refund guidelines.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

Explanation of benefits

- 129 – Prior processing information appears incorrect.
- Note: A refund is required in the amount of \$205.62 (for CPT Code 90837x 2 units, total refund amount \$411.24).

Issues

1. Did the insurance carrier request a refund within the time allowed per 28 Texas Administrative Code §133.260(b)?
2. Did the insurance carrier request a refund in the manner identified in 28 Texas Administrative Code §133.260(b)?
3. Did the requestor appeal the refund request?
4. Did the insurance carrier act on the health provider's appeal within 45 days after the date on which the health care provider filed the appeal?
5. Did the requestor remit the refund with any applicable interest within 45 days of receipt of notice of denied appeal prior to the filing of MFDR?

Findings

1. 28 Texas Administrative Code §133.260(a) states in pertinent part "An insurance carrier shall request a refund with 240 days from the date of service or 30 days from completion of an audit performed in accordance with §133.230 (relating to Insurance Carrier audit of a Medical Bill), whichever is later, when it determines that inappropriate health care was previously reimbursed, or when an overpayment was made for health care provided"

The requestor seeks resolution of an insurance carrier refund request for services rendered on July 28, 2014 and August 14, 2014. On December 22, 2014, the insurance carrier requested a refund from the requestor for services, which it had reimbursed a total of \$411.24. The division finds that the insurance carrier met the requirements of 28 Texas Administrative Code 133.260(a).

2. 28 Texas Administrative Code 133.260 (b) states, "The insurance carrier shall submit the refund request to the health care provider in an explanation of benefits in the form and manner prescribed by the Division."

Review of the submitted documentation supports that the insurance carrier issued EOB's in their request for a refund. The EOBs are dated December 22, 2014 the same date as the refund letter issued by the insurance carrier. The Division finds that the insurance carrier met the requirements of 28 Texas Administrative Code 133.260 (b).

3. 28 Texas Administrative Code §133.260 states, "(c) A health care provider shall respond to a request for a refund from an insurance carrier by the 45th day after receipt of the request by: (1) paying the requested amount; or (2) submitting an appeal to the insurance carrier with a specific explanation of the reason the health care provider has failed to remit payment."

The requestor appealed the insurance carrier's request for a refund on December 30, 2014, with a letter stating, "The services in question were related to the compensable injury, they were preauthorized by IMO and the referral came from the treating DWC approved physician. The preauthorization letter with peer review is very clear about the *causation* and medical necessity for said services and the services are in accordance with ODG." The division finds that the requestor met the requirements of 28 Texas Administrative Code 133.260(c)(1) as the carrier made the request on December 22, 2014 and the appeal was made by the requestor on December 30, 2014, which was within the 45 days as required by Rule 133.260(c)(1).

4. 28 Texas Administrative Code 133.260(d) states, "The insurance carrier shall act on a health care provider's appeal within 45 days after the date on which the health care provider filed the appeal. The insurance carrier shall provide the health care provider with notice of its determination, either agreeing that no refund is due, or denying the appeal."

The insurance carrier acted on the health care provider's appeal on February 3, 2015. The division finds that the insurance carrier responded to the healthcare provider's appeal within 45-days after the date on which the health care provider filed the appeal. The Division finds the insurance carrier has met the requirements of §133.260(d).

5. 28 Texas Administrative Code 133.260(e) states, "If the insurance carrier denies the appeal, the health provider:
(1) Shall remit the refund with any applicable interest with 45 days of receipt of notice of denied appeal; **and**
(2) May request medical dispute resolution in accordance with §133.305 of this chapter (relating to Medical Dispute Resolution – General)."

In this case, the requestor received notice of the alleged overpayment on December 22, 2014. The requestor submitted insufficient documentation to support that the refund was remitted to the insurance carrier after the insurance carrier's denial of the requestor's appeal of the refund request. As a result, the Division finds that the dispute over the insurance carrier refund request, submitted by Glenn J. Bricken and Assoc., was submitted before the refund was issued to the insurance carrier and therefore not meeting the requirements outlined in 28 Texas Administrative Code §133.260(e)(1) & (2). The Division finds that due to the Requestor not remitting the refund to the insurance carrier prior to the MFDR request; the dispute is not eligible for review.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. After thorough review and consideration of the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the review of the refund request. The requestor has failed to establish that the dispute is eligible for review.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor has failed to establish that the dispute is eligible for review.

Authorized Signature

_____	_____	October 29, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.